MEDICAL MALPRACTICE ROUNDS

RECOVERY BARRED WHERE PATIENT FAILED TO REPORT SYMPTOMS

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Many times a practitioner wonders whether the timely disclosure of a symptom would have altered the patient's outcome. Patient failure to disclose symptoms could also have legal implications, as was demonstrated in a Maryland case decided several years ago.[1]

There, the defendant physician examined the decedent patient in March 1983, and discovered "multiple nodularities" resembling "small cysts" in her left breast. The patient was premenstrual. These masses were approximately one centimeter in diameter and presumed to be fibrocystic changes. The physician, a gynecologist, instructed the patient in breast self-examination, advised her that these cystic structures would regress after her period, and urged her to continue to monitor her condition. After several follow-up visits and repeat breast examinations, a referral for a mammogram was made and was performed in December 1983. Mammography results were consistent with fibrocystic changes and revealed no discrete mass or evidence of malignancy.

Self-examinations were continued and in April 1984, the patient appreciated a definite change in her left breast, as if a previous mass seemed to be growing into the side of the breast. By July 1984, she was sure it was much larger and was "pushing out on the side" and could be felt through her clothes. In May, it appeared to be "about one-quarter the size of an egg;" by July, it appeared to have grown to equal the size of an egg. Yet, she never consulted her physician regarding this change, despite testimony that she was instructed to call her physician if she appreciated anything different in her breasts.

Finally, in August 1984, she consulted her defendant gynecologist, who immediately referred her to a surgeon. Biopsy results revealed a malignant tumor, and a radical mastectomy was recommended. Following additional tests, however, liver metastases were detected, and a course of chemotherapy with radiation treatment followed. While still alive, the patient filed a medical malpractice action, alleging that the defendant negligently failed to diagnose her breast cancer; she later died of breast cancer at the age of 36.

At trial, the jury concluded not only that the defendant was negligent, but also that the patient had been contributorily negligent, and recovery was denied. The decedent's personal representative appealed, contending, among other things, that the trial court erred in submitting the question of contributory negligence to the jury. According to this argument, the decedent's failure to report the growing breast lump to her physician could not constitute contributory negligence, since it was not contemporaneous with the physician's negligence and, in fact, occurred much later.

The appellate court reviewed the evidence and found many of the important facts to be in dispute. With regard to the issue of contributory negligence, however, the court reviewed the defense of contributory negligence in medical malpractice cases. A number of states, it was observed, have adopted the view that in order to serve as a bar to recovery in a medical malpractice action, the patient's contributory negligence must be contemporaneous with the negligence of the physician. This position regards any subsequent negligence on the part of the patient as simply exacerbating the damage flowing from the doctor's original negligence.

The court drew a distinction in this case, however, since the injury flowing from the primary negligence was not complete prior to the patient's negligence. In fact, it was observed in this case that the evidence allowed a finding that her failure to seek medical attention did more than simply exacerbate the injury. Instead, her failure appeared to directly contribute to her injury by precluding diagnosis and treatment at a point when the breast cancer probably could have been cured. Under the circumstances, the issue of contributory negligence was properly submitted to the jury, and the patient's failure to report this growing breast mass to her physician, as instructed, could serve as a complete bar to recovery.

A close reading of this case illustrates the two-way responsibility in the doctor-patient relationship. When a physician instructs a patient to return to his office for a follow-up appointment or to report the appearance of certain signs and symptoms, the patient's failure to do so may constitute contributory negligence and bar recovery if that failure prevented diagnosis and cure of the condition.

LIABILITY FOR ACTS OF TRIAGE PERSONNEL

Physicians in emergency departments are frequently assisted by many ancillary personnel, including receptionists, nurses and technicians. Such departments frequently utilize a triage system, through which more urgent cases are identified and treated before routine problems. The medical history-taking ability and physical assessment skills of the triage person are essential in making this initial evaluation. The triage person is expected to recognize the significance of certain situations, such as hemorrhage in the hypotensive patient or fever in a newborn. Triage personnel must take the necessary initial measures to insure expeditious, appropriate treatment, such as the placing of a severely injured patient in a "trauma room" and immediately securing the attendance of the physician. This limited exercise of proper professional judgment is crucial to the efficient functioning of the emergency department, and the failure to exercise such judgment, care and skill can provide a basis for hospital liability.

In one interesting case,[2] two children were brought to the emergency room suffering from rashes and high fevers. The parents related to the nurse that they had removed several ticks from one of the children. The nurse allegedly failed to inform the emergency physician of this history, and the children were misdiagnosed as having measles. In fact, they both had Rocky Mountain Spotted Fever, and one later died. The appellate court vacated a judgment for the hospital, holding that the negligent failure by the nurse to relate a relevant history which resulted in misdiagnosis could render the hospital liable for the resultant injuries.

In another case,[3] the parents of an infant brought her to the emergency room and related a history of irritability, difficult breathing, and the refusal of the infant to eat. The nurse on duty sent them away. When they returned several hours later stating that the child was worse, the same nurse observed the infant and felt her head, at which time she reassured the parents that there was no emergency. After approximately 12 hours the child expired from pneumonia. A fact question was presented as to whether the defendant hospital's nurse had made a negligent triage decision. Legal responsibility is thus borne by all members of the emergency department's health care team, and the negligence of any such employee can subject the hospital to liability.

In a different case with related circumstances, the hospital was not held liable for the negligence of a nurse assisting the physician in rendering emergency treatment in the emergency room. Any negligence on the nurse's part related to the exercise of her professional judgment. No injury resulted from the hospital's administrative or clerical negligence.[4]

A fact question, however, was presented in another case as to whether the negligence of the nurse is separate from the negligence of the treating physician where the nurse observed that the patient was in pain and alerted the physician who failed to examine or treat the child.[5] The child died from meningococcemia which could have been successfully treated had a proper examination been conducted in the emergency room. The failure of an emergency room nurse to take and record the infant patient's vital signs and take a complete medical history raises a fact question as to negligence.

Paramedics render some degree of medical treatment when they transport injured and ill persons to the hospital in the course of ambulance service. Paramedics are not physicians and cannot be held liable for failing to diagnose the severity of the injuries. Therefore, in an instance where paramedics transported a shooting victim to the nearest emergency room rather than to another hospital with a thoracic capability, it was not negligence as there were no previously designated trauma centers for different types of injuries.[6]

SOME COURTS FAVOR INTERMEDIATE STANDARD OF CARE

Although residents approaching the end of their training should have almost as much experience as some fully-trained specialists in their field, other residents may have undergone only several months of specialty training. When medical negligence is alleged, courts grapple with the question of whether to hold the resident practitioner to the standard of the generalist or the specialist. Some courts have adopted a middle ground.

In a Pennsylvania case,[7] the decedent, then 85 years of age, fell at her home and sustained a fractured wrist. She was seen some time later at the Emergency Department of a local hospital by an orthopedic resident, who applied a cast. Ten days later, the cast was removed, revealing evidence of infection. An ulcer developed, and blood cultures grew staph aureus. Antibiotic therapy appeared to initially arrest the infection, but related complications developed, and the patient died.

At trial, the court instructed the jury that a resident was a licensed physician receiving training in a specialty, but that a resident was neither a fully-trained orthopedic specialist nor a general practitioner with no specialized training. Accordingly, the jury was instructed that the applicable standard of care obliged him to exercise that degree of skill, learning, and care normally possessed by other orthopedic residents in the same circumstances.

A jury verdict for the defendant physician was returned, and an appeal was brought. The appellant, who was the administrator of the estate, contended that the trial court erred in instructing the jury as to the applicable standard of care. The appellant argued that an orthopedic resident must be held to the same standard as a fully trained orthopedic surgeon.

The appellate court reviewed the position of other jurisdictions on the subject and found "a dearth of case law" on the resident standard of care. After examining the issue, it concluded that it would be "unrealistic" to require a resident to meet the same standard of care as a fully trained specialist. Residents may have only months of training in a specialized field, while fully trained specialists not only have completed a residency but may also have gained additional years of practical experience.

Nonetheless, it was observed that if the resident is given responsibilities which exceed his skill level, the ultimate responsibility for the training and supervision of residents lies with the teaching hospital, and future plaintiffs would have recourse against that institution. In this case, the jury instructions were not found to be in error. The court affirmed the judgment.

In short, the selection of an appropriate standard of care for resident physicians presents courts with difficult choices. The adoption of an intermediate standard of care by this Pennsylvania court, under the circumstances, was intended as a reasonable compromise.

REFERENCES

1. *Chudson v. Ratra*, 76 Md. App.753, 548 A.2d 172 (1988).
2. *Ramsey v. Physicians Memorial Hosp., Inc.*, 36 Md. App. 42, 373 A.2d 26 (1977).
3. *Richard v. Adair Hosp. Found. ,Corp.*, 566 SW2d 791 (Ky. 1978).
4. *Moore v. Carrington*, 155 Ga. App. 12, 270 S.E.2d 222 (1980).
5. *Anthony v. Hosp. Serv. Dist. No. 1*, 477 So.2d 1180 (La.App. 1985).
6. *Morena v. South Hills Health Sys.*, 501 Pa. 634, 462 A.2d 680 (1983).
7. *Jistarri v. Nappi*, 378 Pa. Super 583, 549 A.2d 210 (1988).